MS 561 (8/96) Revised **CONFIDENTIAL**

EAP SUPERVISORY REFERRAL FORM

General Instructions: The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal-medical problem.

(PLEASE PRINT IN INK OR TYPE) REFERRAL DATE: _____

EMPLOYEE'S NAME: _____ SS#:_____

STREET ADDRESS: _____ HOME PHONE: _____

CITY, STATE: _____ WORK PHONE: _____

ZIP:_____ DOB:_____

CLASSIFICATION: _____ GRADE:_____ EOD:_____

DEPARTMENT WORK LOCATION: _____

ADDRESS: _____

WORK HOURS (SHIFT): _____ DAYS OFF: _____

REFERRED BY: _____ TITLE: _____

PHONE NUMBER: _____

EAP COORDINATOR: _____ TITLE: _____

PHONE NUMBER: _____ _____
EAP COORDINATOR'S SIGNATURE

REASON FOR REFERRAL

Please fill in the sections below that are relevant to this referral.

VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE

_____ Failed Random Drug Test.

_____ Alcohol related conviction

ATTENDANCE

_____ Number of days absent in past 12 months.
_____ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays).
_____ Number of extended lunch periods in past 6 mos.
_____ Number of times late in past 6 mos.
_____ Other: _____

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JOB PERFORMANCE

_____ Lower Quality of Work
_____ Decreased Productivity
_____ Increased Errors
_____ Impaired Judgment/Memory
_____ Erratic Work Patterns
_____ Failure to Meet Schedules
_____ Inability to Concentrate
_____ Other: _____

BEHAVIOR DEMONSTRATED

_____ Avoids Supervisors or Co-workers
_____ Less Communicative
_____ Unusually Sensitive to Advice or Constructive Criticism
_____ Unusually critical of supervisor, co-workers or Employer
_____ Loss of Interest
_____ Frequent Mood Swings
_____ Disregard for Safety
_____ Other: _____

HAVE THE ABOVE ISSUES BEEN DISCUSSED WITH THE EMPLOYEE?____ YES ____ NO

HAS THE EMPLOYEE BEEN REFERRED TO THE STATE MEDICAL DIRECTOR?____ YES____NO
IF YES, WHEN?_____(Please attach all relevant documentation)

THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE

I understand that my employer is referring me to the State's Employee Assistance Program (EAP). I also understand that my signature below does not reflect my agreement/disagreement to any of the issues raised. My signature verifies that I have seen the referral and all documentation contained therein.

_____ YES, I will participate in the Employee Assistance Program.
My health insurance carrier is:_____

_____ NO, I will not participate in the Employee Assistance Program.

_____ _____
SIGNATURE DATE

Please forward the MS 561 and all supporting documentation in **DUPLICATE** to:

Maryland Department of Budget & Management
Office of Personnel Services and Benefits
Employee Assistance Program
301 W. Preston Street, Rm. 607
Baltimore, Md. 21201

If you have a question, call the Employee Assistance Program on 410-767-1012.

***FAILURE TO FULLY COMPLETE THIS FORM WILL RESULT IN A DELAY IN YOUR APPOINTMENT**

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